The Nordic model": historical origins and its significance for the work place dialogue towards increased organizational sustainability

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Measures to meet Nordic challenges for sustainable health care organizations

Gothenburg 9-10 November, 2017

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Content

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Measures to meet Nordic challenges for sustainable health care organizations
Gothenburg, November 9 - 10, 2017

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Preface

Welcome to Gothenburg and the 11th NOVO-symposium!

The NOVO Network is a Nordic non-governmental professional association, promoting research and development for increased organizational sustainability in the healthcare sector. The vision is "a Nordic Model for sustainable systems in the healthcare sector". The core idea of the NOVO network is to integrate perspectives of work environment, efficiency and quality of care to support sustainable health care systems, as illustrated by the "NOVO triangle". The topic of the 2017 NOVO Symposium is *Measures to meet Nordic challenges for sustainable health care organizations.* The keynote speakers are professor Jari Hakanen and professor Ulrica von Thiele Schwarz.

Over the past three decades, public health care organizations in the Nordic countries, as well as in other countries, have struggled to handle important policy and organizational changes to reduce costs and develop better quality of service. However, the work environment has also become more challenging. For example; work demands, sick-leave rates and employee turnover among health care workers and professionals have increased. This challenges the sustainability of the public health care organizations and society. Studies of sustainable organizational developments point to the importance of integrating the perspectives of effectivity and quality of performance with the development of beneficial working conditions. Leadership, the kind of re-design and development approach as well as the approaches in implementation and supportive conditions have been considered key mechanisms for organizing more sustainable health care. This year's conference will present and discuss these aspects from a wide range of disciplines!

In the 2017 symposium, workshops will be arranged to support sharing and learning between participants and countries. How can we learn from measures and methods that supports sustainable systems, developed by others?

The 11th NOVO Network Symposium has been organized as a collaboration between the University of Gothenburg: the Department of Sociology and Work Science, and the School of Business and Law; The University of Borås: the Faculty of Caring Science, Work Life and Social Welfare; and the Västra Götaland county council: the Institute of Stress Medicine. We wish you all a warm welcome to Gothenburg!

/The local committee

Novo steering group

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Sweden:	Ewa Wikstrom
	Lotta Dellve

Local committee 2017

Members of the local committee are:

Lotta Dellve, University of Gothenburg: the Department of Sociology and Working Science
Pia Jacobsen, University of Gothenburg: the Department of Sociology and Working Science
Ewa Wikström, University of Gothenburg: the School of Business and Law
Lisa Björk: Region Västra Götaland, the Institute of Stress Medicine
Maria Wolmesjö: University of Borås, the Faculty of Caring Science, Work Life and Social Welfare
Sara Larsson Fällman: University of Borås, the Faculty of Caring Science, Work Life and Social Welfare

Program

Venue: Gothenburg University, Campus Haga, Sprängkullsgatan 25, Sappören

Wednesday 8th of November 2017

18.30 Registration open. Mingle party with music and a light meal (ends at 21.00)

Thursday 9th of November 2017

8.30 **Registration open**

9.00 **Symposium opening & welcome**

9.10 **Keynote presentation**
Professor Jari Hakanen. *The drivers of work engagement – focus on servant leadership, job resources, and job crafting*

10.00 **Session 1: Sustainable management and leadership**
Moderator: Maria Wolmesjö, Sara Larsson Fällman

Andersson Bäck et.al. *Medical manager hybrids for handling institutional complexity and change in primary care*

Jutengren, Jaldestad et.al. *The potential importance of social capital and job crafting for work engagement and work satisfaction among health care employees*

Orvik, et al. *Towards sustainable workplaces in health care organizations through organizational health*

11.00 **Fika**

11.20 **Session 1: Cont.**
Hasle et.al. *From top-down bureaucracy to local bureaucracy in hospitals*

Dellve & Larsson Fallman. *Systematic Occupational Health and Safety Management (SOHSM) and Psychosocial Safety Climate: concepts, assessments and associations with indicators of health, quality and efficiency*

Kjellström et.al. *Leadership as a driver for work motivation: a study of well-functioning primary healthcare centers in Sweden*

Eriksson et.al. *Success factors for development of health-promoting and sustainable leadership in healthcare– Learnings from an intervention study*

Sinervo, et al. *Service integration and new competences in health and social care*

12.40 **Lunch**

13.40 **Workshop: Measures and methods to improve sustainability**

Workshop A
Moderator: Maria Wolmesjö, Sara Larsson Fällman

Kjellström et.al. *Research on successful and well-functioning organizations: The role of qualitative studies for theoretical and practical use*

Bååthe & Rø *Identifying measures to monitor the effect of local clinical physician improvement initiatives*.

Hultberg & Winroth. *Process support as a method for changing work*

Workshop B
Moderator: Ewa Wikström

Winkel J, et al. *The NOVO Network: the original scientific basis for its establishment and our R&D vision*

Schiller B. *The Nordic model": historical origins and its significance for the work place dialogue towards increased organizational sustainability*

Workshop C
Moderator: Lisa Björk

Lindgren H. *The Emergence of a Change Model 2005-2017. Perspective Laboratorie*

Öien et al. *To investigate how a bed-side app linked to a national quality registry can be used in everyday clinical wound management.*

Sjøvold. *The art of building high-performance teams – an introduction to the use of SPGR for researchers and practitioners.*

15.10 **Fika**

16.00 **Social program** with guided tours at *Göteborgs Stadsmuseum*

19.00 Conference dinner at *Fiskekrogen*

Friday 10th of November 2017

9.00 **Keynote presentation**
Professor Ulrica von Thiele Schwarz. *Designing, implementing and evaluating sustainable improvement initiatives in healthcare organizations*

9.45 **Session 2: Innovative health care**
Moderator: Ewa Wikström

Bergerum et.al. *Patient involvement in healthcare quality improvement – a realist literature review*

Öien, et al. *Shortcut to a better and safer care for patients with hard-to-heal ulcers*

Wolmesjö, Skagert, et. al. *Sustainable organisation towards an attractive work environment in home help care*

10.45 **Fika**

11.15 **Session 2: Cont**

Avby et.al. *A reform as a lever for innovation and professionalism?*

Strömgren. *Social capital – a resource associated to intention to leave among health care professionals*

Øygarden, et. al. *Establishing a multidisciplinary day care surgery department: organizational change, institutional logic conflicts, compromises and consequences.*

12.15 **Lunch**

13.15 **Session 3: Implementing organizational re-design**
Moderator: Lotta Dellve

Wikström, Erichsen et.al. *Implementing Aseptic Techniques in the Operating Room: Facilitating mechanisms for Contextual Negotiation and Collective Action*

Sjøvold et.al. *New technology in developing interdisciplinary teams*

Jolanki, Sinervo et.al. *Professionals' views on integrated care*

Edwards. *How many EMA-workshops are needed to collect a representative sample of events in a hospital ward?*

14.45 **Fika**

15.00 **Session 4**
Moderator: Lisa Björk

Piippo, et.al. *Self-managing working-teams*

Williamsson et.al. *Visual management; condition or consequence to social capital and clinical engagement among nurses?*

André et.al. *The impact of certification of the "Joy of Life" in Nursing Homes on the improvement of working methods and attitudes among staff in Nursing Homes*

16 – 16.30 **Closing and summarizing the conference** and a look at the future
Key-notes Jari Hakanen, Ulrica von Thiele Schwarz
Local committee, NOVO chair

Keynotes

Jari Hakanen *is Research Professor at the Finnish Institute of Occupational Health. He is also Adjunct Professor in social psychology at the University of Helsinki, where he obtained his PhD. He is particularly interested in phenomena related to positive work psychology and employee wellbeing, such as the JD-R model, work engagement, burnout, work-family enrichment, job crafting, and servant leadership. He has received several international and national awards, for example the best paper award in 2011-2012 in the Journal of Occupational Health Psychology and the Finnish Work-life Researcher of the Year award in 2012. He has also developed and implemented several research based positive interventions in organizations to enhance work engagement and flourishing workplaces.*

The drivers of work engagement – focus on servant leadership, job resources, and job crafting

Two major changes in work and organizational psychology and occupational health psychology have been taking place during this millennium. First, the rise of positive psychology meant that employee-well-being was not anymore only considered from its opposite (stress, burnout) or being satisfied at work but attention was given to true well-being at work (work engagement, flourishing). Second, traditionally organizational top-down approaches have dominated how to develop and improve psychosocial working conditions and how to impact employee well-being. However, until this decade quite little has been known about the extent to which employees themselves can also create a better fit for themselves with their working conditions, that is, job demands and resources. Job crafting represents such a bottom-up approach, which may complement traditional top-down work arrangements.

In this keynote, by using research evidence both from health care sector and other sectors, I will provide an overview of the concept of work engagement, its prevalence, outcomes and important drivers: servant leadership, job resources, and job crafting. Work engagement has been defined as a positive and fulfilling, relatively stable state of well-being at work consisting of feeling vigorous, dedicated, and absorbed at work. Often work engagement has been investigated using the job demands-resources (JD-R) model, in which various job resources are expected and found to enhance work engagement whereas different job demands are known antecedents of burnout. Moreover, according to the model, work engagement is expected to lead to such positive organizational outcomes, such as organizational commitment, job performance, and innovativeness. Although job demands and burnout are assumed to lead to (negative) health outcomes, there is evidence supporting the positive relation between work engagement and physical and mental health.

In addition to job resources, there is a growing number of research focusing on what leaders can do to boost work engagement in their followers and what employees themselves can proactively do to increase their engagement and stay engaged. In my talk, I will discuss the role of servant leadership and job crafting in employee engagement. Servant leadership is a leadership theory and set of practices that particularly aims to serve followers for their own good, not just the good of the organization, and encourage their growth and development so that over time they may reach their fullest potential. Job crafting, in turn, can be defined as self-initiated future oriented behaviors and cognitions that employees can use as proactive strategies to find better fit with their jobs and thereby feel more engaged at work.

In addition to all the potentials the above mentioned concepts hold, the possible negative consequences, if any, of feeling engaged, crafting one's job, and acting as a servant leader will be discussed as well as their applicability in health care settings.

Ulrica von Thiele Schwarz *is a Professor in Psychology at Mälardalen University. She also co-leads the Procome (process-outcome) research group at the Medical Management Centre, Karolinska Institutet. Her research theme is applying a behavioral perspective to interventions and continuous improvements within the work setting. Overall, the research is concerned with further the understanding on effective implementation and links between work conditions, health and productivity. In the field of implementation, she is intrigued by the adherence and adaptation dilemma and by how stakeholders across the research-to-practice pathway can contribute to making evidence useful in practice.*

Designing, implementing and evaluating sustainable improvement initiatives

Healthcare is under constant pressure. This is fed by multiple sources: the fast technological and knowledge development, a population that is growing older and where chronic illness is more and more common, challenges in recruiting and retaining staff and managing demanding working conditions, and financial pressure. To meet these challenges, healthcare organizations is constantly involved in (more or less) planned initiatives to make improvements in the way work is organized, designed and managed. These initiatives go under different names depending on the main focus, and thus, can be found under alias such as occupational health and safety interventions, quality or process improvements or implementation of evidence-based methods and technology. Both in practice and in research, these initiatives often live separate lives, existing in silos that do not often meet. This presents a lost opportunity to learn across disciplines and practices, prevents synergies and risks introducing conflicting procedures that, all together, may hamper the sustainability of improvement initiatives. It can be argued that the approaches taken to manage – and research -- these change process are similar regardless of their name and main focus. This keynote aims to present an integrated view on how sustainable improvement initiatives in health and social care organizations can be designed, implemented and evaluated – and researched.

The research on how sustainable improvement initiatives can be designed, implemented and evaluated is undertaken in multiple disciplines, for example occupational health and safety, organizational psychology, organizational change, change management, implementation science, quality improvement, operational management and applied ergonomics. These represent different schools of thought, which provides an intriguing and challenging backdrop to any effort to design, implement and evaluate improvements in organizations. In this presentation, experiences from conducting practice-close research within the fields of implementation science, improvement science and occupational health will be shared, contrasted the assumptions and practices in the different fields of research and their potential contribution to the goal of achieving sustainable improvements in healthcare.

Yet, despite differences between fields of research, there are also communalities. This presentation will highlight some of these. For example, the literature points to the role of participation, the importance of alignment of different objectives and initiatives and integration with ongoing practices and process, as wells as the need to understand the context of change (e.g. the organization) in order to achieve sustainable impact. Recently, it has also been acknowledged that improvement initiatives seldom can be characterized as simple, episodic changes. Instead, they are often dynamic; ongoing, iterative and highly interdepended on the context where they are taking place. This has implications for how changes are evaluated. It is increasingly being argued that traditional evaluation methods have erroneously assumed that improvement initiatives in healthcare are episodic and context-independent. In response to this, a framework for how dynamic, integrated and context-dependent changes can be designed, implemented and evaluated will be presented along with empirical and practical examples of how the design, implementation and evaluation can play out in practice.

Social program

Wednesday 8th of November 2017

18.30 Registration open. Mingle party with music and a light meal (ends at 21.00)
The Elin, Albin & Oliver trio gives you cool sounds of jazz. The trio interprets well known jazz tunes in a playful way and creates a warm atmosphere.

Thursday 9th of November 2017

16.00-17.00 **Social program** with guided tours at *Göteborgs Stadsmuseum, Norra Hamngatan 12, Gothenburg. Start at the reception/entrance.*
Please be on time!

There will be different groups, for example:
The Birth of Gothenburg. Permanent exhibition from 17th Century. Part of Gothenburg's 400th anniversary. Guided in Swedish.
Vikings- between Oden and Christ. Permanent exhibition. Guided in English.

For further information: www.goteborgsstadsmuseum.se

19.00 **Conference dinner** at Fiskekrogen
Fiskekrogen has served delicious fish dishes since the beginning of the 1970s and claims its place as the best fish and shellfish restaurant in town.

On the ground where the restaurant is located Niklas Sahlgren lived in the 1700s. Sahlgren was the director of the Swedish East India Company and also an important benefactor to the main hospital of Gothenburg, named after him.

Abstracts, by presenting author and in alphabetical order

Medical manager hybrids for handling institutional complexity and change in primary care

Monica Andersson Bäck, Department of Social Work; University of Gothenburg; Gothenburg, Sweden.
Gunilla Avby, The Jönköping Academy for Improvement of Health and Welfare; Jönköping University; Jönköping; Sweden.
Kristina Areskoug-Josefsson, The Jönköping Academy for Improvement of Health and Welfare; Jönköping University; Jönköping; Sweden.
Sofia Kjellström, The Jönköping Academy for Improvement of Health and Welfare; Jönköping University; Jönköping; Sweden.

Introduction
This article deals with hybrid persons combining medical professionalism and management for handling institutional complexity and change in primary care. Primary care and identity are in transition in many western countries, in Sweden emphasized by the 2007 reform for patient choice and competition. Research has shown that embedded hybrid actors, familiar and socialized in a field and to its logics, tend to be influential for handling complexity and change. Yet hydrids and their enactment in primary care is an underexplored area.

Aim
The aim is to contribute to our understanding of hybrid persons and how they are combining medical professionalism and management in primary care, while managing complexity and change.

Material and methods
In a case study of six successful primary healthcare centers, public and private, covering 56 interviews and observations with various professions, two medical managers 'hybrids' showed to be particularly interesting. These were analyzed in-depth, including analysis of staff's and colleagues' experiences and contrasted by other managers and hybrids. For the analysis we draw on institutional logic perspective (Thornton, Occasion & Lounsbury 2012) in order to capture preconditions as well as enactment of such change agents.

Results/conclusions
The hydrids contributed to innovation, creativity and learning in their primary care centres. At their workplace, coherence and a good ambience coexisted with feelings of high work pace and lacking role clarity among the multidisciplinary staff. Categorized in line with McGivern and colleagues (2015) term as 'willing hybrids', the persons studied revealed high ambitions to challenge existing institutional order giving professionalism new forms, while seeking to innovate practices and division of work among healthcare staff in primary care. By doing so the hybrids integrated professionalism and managerialism and were influential in reframing problems and solutions, which aligned several logics at play. However several obstacles related to professional as well as bureaucratic issues appeared along the way.

The impact of certification of the "Joy of Life" in Nursing Homes on the improvement of working methods and attitudes among staff in Nursing Homes

André, Beate, RN, PhD,
Jacobsen, Frode F. RN, PhD, Professor ,
Sjøvold, Endre, PhD, Professor,
Haugan, Gørill, RN, PhD, Professor
Department of Nursing Science, Norwegian University of Science and Technology (NTNU)
& NTNU Center for Health Promotion Research

Background
Both recruitment and retention of health professionals are a major problem in nursing homes. Implementation of "Joy of Life" assumes that the leader of the nursing home is an active part, encouraging employees to update themselves professionally, has co-determination and good access to information, and that the working environment is more focused.

Purpose
Gain knowledge of how the implementation process of the "Joy of Life" certification affects the staff's working methods and attitudes to promote happiness for the elderly residents.

Method
All employees in Trondheim municipality at nursing homes, community care hospitals and welfare and rehabilitation centers were sent a questionnaire to their municipal e-mail. The questionnaire itself consisted of 26 questions, two of which focus directly on the implementation process that is the focus of this study. Respondents answered the same questions at two different points of time, indicating any changes over time.

Result
The findings show two factors of interest; 1) The ability to apply the "Joy of life" certification process to change work routines or methods is affected over time so that when the nurses have gone further in the certification process they find it more useful to use the implementation to change work methods and routines. 2) The certification process has an impact on the staff's attitudes towards how an employee can work to promote "Joy of Life" for the residents.

Conclusions
The findings indicate that the importance of the certification process increases over time. Moreover, it appears that that when working in a nursing home where "Joy of Life" is implemented and the longer a nursing home has been certified, the more useful the actual work process seems to be.

A reform as a lever for innovation and professionalism?

Gunilla Avby[1], PhD;
Sofia Kjellström[1], PhD
Monica Andersson Bäck[2], PhD
[1]The Jönköping Academy for Improvement of Health and Welfare, Jönköping University, Sweden. [2]Department of Social Work, University of Gothenburg, Sweden.

Introduction
Consistently with international trends, managerial reforms and incentive systems in Sweden have been introduced to achieve quality improvement and increased efficiency in welfare services. Evidence suggests that targeted financial micro-incentives can stimulate change in certain areas of care, but they do not result in more radical change, such as service transformations or innovation.

Aim
In this study we explore how organizational performance are changing within the context of a patient choice reform in primary healthcare.

Material and Methods
This qualitative study is based on 48 semi-structured interviews with various professions (managers, physicians, nurses, physical- and occupational therapists, care administrators, and nurse assistants) at five PHCCs, conducted as part of a study designed to explore financial incentives and motivation in PHC in Sweden. The PHCCs were purposively selected to ensure the inclusion of both public and private facilities. All centers had a longstanding reputation for good leadership and high quality care.

Results
The findings show how professional fields and traits were dissolving and changing, triggering the emergence of innovative solutions in practice. Through ongoing negotiations of professional boundaries new practices unfolded and professionalism increasingly was achieved through contextual conditions. The expanding and changing of professional boundaries as shown in the study are implied to stimulate innovative processes. Thus, the main findings suggest that innovative practices developed as a relationship between contextual conditions and professionalism. E.g. nurses and physical therapists remitted patients directly to the hospital, multiprofessional teams for patient groups with joint needs handled patients that previous needed hospital care, and nurse assistants became responsible for summing patients with minor hypertension for blood pressure controls and consultations.

Conclusions
The reform seemed to act as a lever for innovation and professionalism under certain conditions. How work is organized and managed is a contextual factor that not only affects work circumstances, but also provides conditions for innovation and professionalism. Impartial to governments' ambitions to improve their responsiveness to the needs of citizens by altering market rules, new provider models may be of little assistance in achieving the desired effect on health sector reform outcomes if suitable contextual conditions are missing.

Patient involvement in healthcare quality improvement – a realist literature review

Carolina Bergerum PhD student, University of Borås and Jönköping University
Johan Thor, Associate professor, Jönköping University
Maria Wolmesjö, Associate professor, University of Borås
Karin Josefsson, Associate professor, University of Borås

Introduction
Patient involvement in healthcare improvement is gaining interest. Patients carry valuable experiences of living with different health conditions and of receiving healthcare, which can contribute to healthcare quality improvement (QI), i.e. efficiency and quality of care. In line with this, healthcare professionals are increasingly expected to involve patients, and healthcare organisations and their leaders are expected to support such efforts. This perspective affects the work environment. Yet, there is not a universally applicable definition of patient involvement, and there is little knowledge of how to organise for it.

Aim
To identify examples of patient involvement in healthcare QI, and to reveal the mechanisms that contribute to its success or failure. Furthermore, to outline key considerations when organising and managing patient involvement in healthcare QI efforts.

Material and method
This realist literature review, based on articles in the healthcare context, focuses on QI efforts involving patients as well as healthcare professionals and/or managers and leaders. Based on such reports, context-mechanism-outcome configurations and simple rules for effective patient involvement were articulated.

Results
The initial literature search yielded 492 articles published between January 2011 and February 2016. Of these, 25 met inclusion criteria. The articles exhibited a diversity of patient involvement approaches at different levels of healthcare organisations. Many problems and interventions in healthcare are complicated or complex. The realist review generated three simple rules for how to organise and manage patient involvement in healthcare QI efforts: 1) involve the appropriate microsystem from the outset, 2) support interaction and partnership within the microsystem, and 3) design QI efforts to fit the healthcare problems, the patient involvement level and the contexts at hand.

Conclusions
How to organise and manage sustainable patient involvement in healthcare QI efforts is important and affects the work environment of healthcare professionals as well as their leaders. Successful organisational support of such QI efforts requires clarity on the level of patient involvement, involves the relevant microsystem members and clarifies their roles and responsibilities from the start. Furthermore, it addresses interaction and partnership within the microsystem, and tailors QI efforts to their context to achieve the desired outcomes.

Work-shop: Identifying measures to monitor the effect of local clinical physician improvement initiatives

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Karin Isaksson Rø, MD, PhD. Institute for studies of the Medical Profession, Oslo; Dept. of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo; Resource Centre Villa Sana, Modum Bad, Norway.

Introduction
Securing and enhancing quality of health care is a never ending challenge. Researchers argue that improvement work now also needs to promote good work environment for healthcare employees. We have therefore initiated an interactive and collaborative clinical study about the *interactions between job satisfaction, organizational factors, and quality of care*. Ideally all categories of health workers should be included. Since physicians have a powerful position in healthcare and do not engage much in organizational improvement work, we have started with physicians' perspective. In this process we need measures of quality of care and of satisfaction that physicians find relevant to follow, and which are sensitive enough to register impact from local change initiatives.

Material and methods
This is an interactive and collaborative study using qualitative and quantitative methodology. After exploring how physicians understand the relationships between physician satisfaction, organizational factors and quality of care using semi-structured interviews, the hospital department is challenged to use this knowledge to design locally owned change initiatives. Both sustainable clinical benefits and scientific progress are strived for.

In addition to the interview findings we will track development over time of measures for quality of care and physician satisfaction. Several measurements are captured at the hospital. We need to choose measures relevant for physicians and sensitive for monitoring change.

Results
Based on the interviews, the researchers´ understanding of the clinicians´ everyday reality was presented and as a result the department is organizing 4 physicians to have dedicated time to include bottoms-up knowledge when grappling with top-down work environment challenges. There is not yet a decision about which measures to use to monitor changes in a meaningful way.

Aim of workshop
After a short case summary, we aim to exchange experiences with other researchers about measurements useful for sustainable engagement of physicians, relevant for quality of care and sensitive enough to monitor change, in hospital settings.

Conclusions
Understanding the complex interactions between physician satisfaction, organizational factors and quality of care is imperative for health care systems challenged to improve care delivery and work environment with cost containment. We need good quality-of-care measures to monitor improvement initiatives.

Systematic Occupational Health and Safety Management (SOHSM) and Psychosocial Safety Climate: concepts, assessments and associations with indicators of health, quality and efficiency

Lotta Dellve[1,2,3] **& Sara Larsson Fallman**[2,3]
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Academy of Care, Work and Welfare, University of Borås, Sweden

Introduction
Systematic occupational health and safety management (SOHSM) (Saksvik and Quinlan, 2003) and Psychosocial safety culture (PSC) (Dollard & Bakker 2010) is two theoretical concepts focusing on the prevention of occupational disorders and the promotion of health-related sustainability of workers. Both concepts (SOHSM and PSC) is concerned with practices and procedures in organizations, e.g. what managers and organizations actually do, regarding managing and organizing work environment issues. In Sweden, SOHSM is regulated by law but can be applied in different manners. A more defined and functional SOHSM have been associated with the 5-year prevalence of work attendance among health care workers (Dellve, et al 2008). However, there are several challenges in the assessment of SOHSM and PSC and a need to develop concepts and measures.

Aim
The aim is two-folded (1) to present a conceptual analyses of Systematic Occupational Health and Safety Management (SOHSM) and Psychosocial Safety Climate (PSC) and how it is assessed, and (2) to assess associations between degrees of SOHSM/PSC with trends of health indicators in health care units.

Material and methods
Yearly questionnaire data answered by managers regarding SOHSM and PSC during 3 years and at 2 hospitals (n=150). 5-year register-data of employees' sick leave. Associations with health indicators, quality of care and efficiency were analyzed in relation to unit characteristics of SOHSM and PSC.

Results
The conceptual analysis found similarities and differences. SOHSM is defined as the managerial work practice to fulfill formalized, regulatory framework for organizations to manage workers health and safety. PSC is defined as "polices, practices and procedures for the protection of worker psychological health and safety". Important conditions of SOHSM are: (1) leadership, in meeting legal obligations and directing the organizations' daily work; (2) routines that provide regular feedback to employees, (3) employees' participation and influence in identifying and solving problems, and (4) effective systems for evaluation of goal achievements within SOHSM. Important conditions of PSC are: (1) senior management support and commitment to the prevention of ill-health; (2) the priority management gives to psychological health and safety vs productivity goals; (3) organizational communication in relation to psychological health and safety; (4) the extent of involvement by major stakeholders (e.g. employees, unions and OHS representatives) in relation to psychological health and safety. Thus, the concepts are quite similar but developed from different scientific disciplines and related to concepts within these. There were weak to moderate associations between dimensions of SOHSM/PSC and quality of care, working conditions and efficacy. Associations with trends of sick leave will be presented.

Conclusion
The systematic managerial work to prevent occupational disorders and promote health and safety have importance for workers health, quality of care and efficiency. Combined applications can support further theoretical development and assessments.

How many EMA-workshops are needed to collect a representative sample of events in a hospital ward?

Kasper Edwards, PhD, Senior Researcher, DTU Management Engineering

The effect modifier assessment (EMA) method (Edwards & Winkel, 2016) is a method for assessing the impact of an intervention and modifiers on a desired outcome e.g. improved work environment. The EMA-method captures events (a change in work) in a ward and for each event asses 1) impact on work environment and 2) if the event was part of the intervention or not. The EMA-method rely on the EMA-workshop – a structured group interview method inspired by the chronicle workshop (Limborg & Hvenegaard, 2011) to collect data.

However, healthcare organizations are complex and staff carry out many different and diverse tasks. This poses a problem when using the EMA-method and raises the research question of this abstract: How many EMA-workshops are needed to generate a representative collection of events in a ward?

Methods
Six EMA-workshops each with a full surgical team of six people was conducted in a heart surgery ward with 150 employees (Edwards & Teewes, 2015) . The collected events from all workshops was analyzed and grouped into themes. Data was considered representative when the next workshop did not produce any new themes (saturation).

Results
In the test case, most if not all employees focused on surgery. The ward was organized in three specialties: Heart surgery, Lung surgery and Child heart surgery. Events differed between specialties and therefor it was expected that saturation would be reached after minimum three workshops.

The heart center is comparable to other surgical units and will exhibit a lower degree of variation in work tasks and processes than a medical ward.

The general recommendation is that each EMA-workshop include participants from all relevant occupational groups for a specialization. A specialization should be understood broadly as they may not be formally defined but have developed over time e.g. a specific patient group.

The number of needed EMA -workshops depend on the number of specializations and researchers should uncover the extent and number of specializations before deciding the number of workshops. The number of EMA-workshops is recommended to be at least equal to the number of specialties relevant to the study.

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Success factors for development of health-promoting and sustainable leadership in healthcare– Learnings from an intervention study

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Background
Leadership is considered a key conditions for organizing more attractive work with beneficial working conditions, employees health and work engagement. Health care managers in specific need functional support, competence and handling strategies to meet challenges related to working conditions.

Aim
The aim of this study was to map out success factors for interventions aiming at developing health-promoting and sustainable leadership in healthcare.

Material and methods
In this study the implementation of an intervention program based on system theory was evaluated. The program included evidence-based knowledge of key-factors and conditions for improving workers health, wellbeing and work engagement. 6 groups of 65 managers and organizational key actors were participating in the intervention program. The program was evaluated through interviews (n=44) and questionnaires to managers (n=37) and employees (n=348) before and two times after the intervention program.

Results
The survey results indicated improvements in leadership (p-value 0,00), handling of work environment issues, (p-value 0,00) as well as job satisfaction (p-value 0,05) and work engagement (p-value 0,02) at the workplaces where the managers had actively worked according to the leadership program. Improvements of work processes and quality of care were also to higher extent reported (p-value 0,00) at the workplaces actively working according to the program. Multilinear analysis pointed at that opportunities for continuous dialogues on work environment issues as well as high levels of social capital were important pre-conditions for improvements following the interventions. The analysis of the qualitative interviews pointed at that important success factors for concrete actions at workplace level were managers' own delimitation and prioritization of systematic work environment work, dialogue-based intervention methods, inter-organizational collaboration between OHS, HR and managers at different organizational levels and functional collaboration between researchers and organizational stakeholders.

Conclusions
Successful developments of health-promoting and sustainable leadership require that health care organizations set aside time for systematic reflections and dialogues on improvements of the work environment. Social capital is critical resource for successful leadership interventions including improvements of the work environment. Future research and future intervention within healthcare can thus be recommended to explore measures contributing to increased social capital among employees.

From top-down bureaucracy to local bureaucracy in hospitals

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Introduction
Healthcare professionals in hospitals often voice strong criticism of top-down bureaucracy. They experience management systems and change processes initiated by the management as hampering their possibilities to deliver the best possible patient care. However, does healthcare staff perceive bureaucracy developed at the local level (ward and department) in identical ways? If not, what are the requirements for it to succeed?

Methods and material
We analysed local collaborative practices in a qualitative study of eleven clinical departments from four university hospitals in the Copenhagen region.

Results
Co-existing with the centrally controlled systems and procedures, we find that the local staff and first line management design and implement organisational features themselves to secure the daily collaboration. These organisational features are often organised in bundles of short meetings, coordination tasks, procedures, planning boards, temporary teams and others. The staff reports that such organisational bundles help facilitating the daily work and collaboration across professions, teams and units. Moreover, they use these bundles alongside central management systems (such as electronic patient records) to compensate for shortcomings in these systems.

Interestingly, the local staff and management voluntarily design these formalised procedures and structures, which largely limits the autonomy of individual professionals. This contrast a traditional perspective on professions which posits that further bureaucracy attempts, let alone self-developed systems would be difficult to find. The requirement, however, is that the staff realises the strong interdependence inherent in care delivery and therefore acknowledge a need for formalising daily collaboration. Another requirement for bureaucracy to succeed at the local level depend on their possibility to develop and manage procedures and systems, thereby also offsetting the autonomy trade-off. Based on our findings, we introduce the notion of the local enabling bureaucracy. This notion indicates that to deliver efficient, quality healthcare, healthcare staff rely on design features associated with bureaucracy, which are developed and implemented in a bottom-up process.

Conclusion
A large potential exists for improving hospital performance by focussing more on the development of local designed collaboration. Top management should provide sufficient latitude and support for designing such local organisational features.

Workshop: Process support as a method for changing work

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Background
In the research project FHV-NySam which focused on "Health promotion and prevention work initiatives trough new forms of cooperation" – process support has been used as a method. Part of this project was about evaluating how new guidelines on work environment were interpreted and applied in various administrations with an increased focus on health promotion and prevention. Another part was about how interaction worked between the leadership in the organization, HR and FHV. The first part of the project focused on collaboration, roles and responsibilities – the second part on changing work based on the new guidelines and the in the final section on evaluation. Process support as a method was applied in the project.

Process support as a method
The idea is based on the fact that the business is the point of departure, which in turn means that our starting point is the organizational level. The change work can be about both health promotion and preventing ill health - where we first make a zero-position analysis and then formulate a goal for the desired position. The choice of initiative, to reach the desired position, is the very basis for the process support – where the responsible for the business and the change work tells of their ´case´. The story (the ´case´) and that it is the business that's owns the issue is central to the method. As the word suggest – it is about following and supporting the process or changing work. The work from here is dialogue as method, but there are also elements of knowledge development that can be relevant and also necessary to develop a common understanding of what the change work is about. The theoretical framework is based on system theory, change theory and pedagogical theory. We have worked as a team in the FHV-NySam- project, where we have been two process leaders – which we recommend. We documented our meetings by recording the stories and the dialogues that followed these stories. The project also included an exchange of experience between different administrations (´case´) as a part of the process.

Results
Process support as a method has perceived as a good form of support in changing work by the participants. One problem was initially to formulate ´cases´ so that there was some clear story to be based on for the process support. The features of knowledge development include – health promotion work – was not sufficient enough to contribute to new skills.

OBS! The workshop will be held in Swedish.

The potential importance of social capital and job crafting for work engagement and work satisfaction among health care employees

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Introduction
Recent research in health care has sought to find out how employee health and engagement can best be promoted. There is longitudinal evidence that social capital play an important role for employers' work engagement. In fact, social capital is an important interpersonal resource that predicts not only work engagement, but also job satisfaction. Besides social capital, the research literature indicates that job crafting have a potential role in the promotion of work engagement and job satisfaction. There is, however, limited knowledge about the mechanisms with which social capital within work groups is conceptually linked to individual job crafting, job satisfaction and work engagement.

Aim
The aim was to examine the intermutual influences of work-group social capital, individuals' job crafting, work engagement, and job satisfaction.

Material and methods
The sample included 240 employees, recruited from 22 health care workplaces in Sweden, who filled in a questionnaire at two points in time (i.e. T1 and T2), 6-8 months apart. Data were analyzed in two steps. First, a longitudinal panel design that tested for effects of T1 work-group social capital on T2 job crafting, work engagement, and job satisfaction respectively were analyzed with a structural regression model that controlled for both temporal and concurrent relations. Second, mediational effects of job crafting were tested following a four-step procedure.

Results
The results confirmed that social capital within work groups was predictive of job satisfaction and work engagement in terms of vigor, dedication, and attention. Adding to previous research, the results also showed that social capital was predictive of both cognitive and relational job crafting.

Relational job crafting had a relatively large mediating effect between social capital and work engagement, whereas the association from social capital to work satisfaction was mediated by cognitive and relational job crafting.

Conclusions
Both relational and cognitive job crafting was enhanced by a strong social capital within the work group. As these kinds of crafting also mediated work engagement and work satisfaction, the result that health care organizations should prioritize aiming to enhance a positive social capital and enable crafting behavior within relational and cognitive crafting.

Professionals' views on integrated care

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Introduction
Integrated care policies have been at the heart of recent health reforms in many European countries. In Finland integration is also seen as an important policy tool in improving care quality and continuity of care, as well saving costs and improving the efficiency of health care.

Aim
This papers studied integration from the perspective of health care personnel working in primary health care clinics. The particular aim was to unravel issues perceived as challenging in terms of integration. The study adds to scarce research on how integration become visible in the everyday practices of professionals involved in actual care.

Material and methods
The study employed data from interviews collected in a research project studying patient choice and integrated care in primary health care clinics in Finland. The interviews were conducted in 5 cities in 17 primary health care clinics in 2014. Among the interviewees there were both medical doctors (N=32) and nurses (N=31). Data was organized and coded with NVivo programme. The detailed analysis was done with discourse analysis which offer tools to analyse how different arguments are brought forward in interview talk.

Results
The typical problem hindering integration was poor communication and insufficient information exchange between professionals, unclear definition of responsibilities between different sectors and professionals, and lacking contacts between health and social care professionals. To secure availability and continuity of care health care professionals did extra work, exceeded their duties and invented ad hoc solutions to address problems at hand. This type of work remains invisible in official reports.

Conclusions
Successful execution of integration requires more attention to local level and everyday practices of clinical work. Work cultures and the functioning of integration and collaboration within clinics and between different actors in health and social care has direct bearing on the quality of care experienced by the patients.

Leadership as a driver for work motivation: a study of well-functioning primary healthcare centers in Sweden

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Introduction
Little is known about how, why, or under which circumstances work motivation is formed and linked to reforms and interventions.

Aim
The aim of this study is to explore work motivation among professionals at well-functioning primary healthcare centers subject to a national healthcare reform which include financial incentives.

Material & method
Five primary healthcare centers in Sweden were purposively selected for being well-operated and representing public/private and small/large units. Forty-three interviews were completed with different medical professions and qualitative deductive content analysis was conducted.

Results
Work motivation exists for professionals when their individual goals are aligned with the organizational goals and the design of the reform. The centers' positive management was due to a unique combination of factors, such as clear direction of goals, a culture of nonhierarchical collaboration, and systematic quality improvement work. Social processes where professionals work together as cohesive groups, and provided space for quality improvement work is pivotal in addressing how alignment is created. The units expressed a collective capacity to produce direction, alignment and commitment.

Conclusions
The design of the reforms and leadership are essential preconditions for work motivation. Leaders need to consistently translate and integrate reforms with the professionals' drives and values. This is done by encouraging participation through teamwork, time for structured reflection and quality improvement work. The values of the study consist of showing how a range of aspects combine for primary healthcare professionals to successfully manage external reforms, and how professionals collectively produce leadership.

Workshop: Research on successful and well-functioning organizations: The role of qualitative studies for theoretical and practical use

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Introduction
Organizations strive to handle external and internal demands, and a lot is being written about the struggles and shortages. However, there are organizations that thrive, combining quality of performance and beneficial working conditions. What can we learn from these cases and how are the best studied? Also, how do we move beyond a list of good looking features that we already know are essential, such as leadership and continuous quality improvement work, in order to produce knowledge which is of practical use.

Goal
This workshop takes point of departure in a study on well function primary care centers. The aim is to share our primary insights from this project and learn from it weaknesses and strengths to inspire to innovative, theoretical and practical meaningful research.

Method
Six primary healthcare centers in Sweden were purposively selected for being well-operated and representing public/private/non-profit and small/large units. In total 56 interviews were completed with various professions (managers, physicians, nurses, physical- and occupational therapists, care administrators, and nurse assistants). At this time, four different qualitative analysis approaches have been used.

Results/Conclusion
Each center reveals inspiring as well as challenging features. In the workshop, we will discuss how we can learn from studying good practice and design to further our understanding on sustainable health care and the use of qualitative methods in this context.

Change laboratories: works through positive differences in micro environments

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The development of our model for "change laboratories" is an emerging process starting in 2005 in Gendering Cases Project, where a model for gender equality was developed. The result of the project was, among other things, noticeably positive development regarding the participants' view of gender equality. The model has then been tested in a number of situations and activities, such as further gender equality projects, spreading tacid knowledge, leadership development at universities, attitude impact on teachers' view of students at college.

The Probational Service in Sweden has chosen to use the laboratory method to work on visualizing and disseminating "quiet knowledge" (competence laboratories in project Livspondus). The working form with change laboratories is also on export to the Norwegian Probational Service.
During this period, international research in complexity science has developed theories and models for influencing organizations based on work with micro environments. Theory says that incremental changes in the smaller context give an overall impact of the system. The concept of "Positive Devience" means that rules for collaborating around the work execution or the implementation of the change project enable the development of positive norms, behaviors and increased scope of active interdependence between actors in their respective contexts. The model of change laboratories is now entering a further transformation, as a large and complex organization wants to establish a major change work. By its size, the organization has had significant difficulties in implementing business development that has been achieved in micro environments.

Instead, there is some frustration, change fatigue and even suspicion of large-scale implementations at operational levels. The project aims to: in safe and forms, jointly develop and spread the dialogue in the business. The project is called Perspective Laboratory and is based on the long and emergent development process of change laboratories, partly on knowledge about perspective understanding and adult development, partly on knowledge and experience about change work of norm circles in micro environments, and in research on Positive Devience as well as knowledge and experience of work with liberating rules in group processes. Support for further dissemination and scaling up of the project for regular activities will be derived from knowledge about change work in complex contexts as well as from the Probational Service change process in project Livspondus. We will present the model and give a working example on how work with liberating rules can be set.

Towards sustainable workplaces in health care organizations through organizational health

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Introduction

Perspectives of sustainability can be integrated in health care organizations by knowledge of work environments, long-term health goals, and whole-system approaches[1-3]. Comprehensive approaches are therefore necessary. The rationality of New Public Management has been to increase sustainability through organizational effectiveness. However, this has arguably transformed health care organizations into economic enterprises that compromise the quality of patient care and the integrity of health care workers and professionals. While research on sustainable workplaces has focused on individual health and public health, the organizational level has received less attention. A concept of organizational health may help to fill this knowledge gap and challenge the privileging of economic values.

Aim

The aim of this paper is to introduce a model of organizational health rooted in the health humanities[4]. In a next step, the aim is to operationalize the model for the evaluation of the intermediate and long-term effects of organizational health on sustainable workplaces.

Material and methods

The paper is informed by postmodern hermeneutics with its critical insights into conflicts in postmodern organizations[5-6]. This approach may be particularly appropriate to the analysis of values in contradictory health care settings associated with work health problems, such as a high level of stress[7].

Results

Organizational health has been defined as the *organizational* capacity to balance the tensions caused by competing values in ways that benefit the organization as a whole[8]. While the model embraces five dimensions[9], this paper focuses on two: The *first* refers to the significance of integrating values of efficiency, quality and integrity, but also to the disintegration of such competing values. The *second* refers to the differentiation between the health of organizations *as a whole* and the *health impacts* of health care organizations on workers and professionals[10-12].

A tentative conclusion

A conceptual model of organizational health can potentially enable health care managers to explore the reciprocal dependency and antagonistic tensions between economic values and human values, and to cope with issues of work health on an organizational level. By operationalization, the model can be developed towards methods and measures for promoting sustainable workplaces in health care organizations.

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Self-managing working-teams – Oral presentation

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Introduction
Buurtzorg model is a management model based of self-managing teams with minimal, or none, involvement of superiors. Teams are responsible for planning and realizing their work. The model, developed in Holland, is rewarded for highest job satisfaction and as having the best results concerning client satisfaction. The model shows also economic benefits related to traditional organization with in health care of elderly. Teams have about 5 – 8 members who are responsible for all of the teams work. They plan schedules, realized caring and co-operate with necessary health care instances. Teams get support from organizations with formal issues ex. counting salaries. Teams have also right to use some of their "income" to develop their work further and individual development when needed.

Aim
Our aim is to evaluate how the Buurtzorg model is implemented in elderly healthcare organizations in two Finnish municipalities.
The aim is also to follow the development process among the teams.
Reserach questions are as follows: 1) Can the model be applied to Finnish health care culture? 2) Does the model improve work ability, well-being at work and client satisfaction? 3) Is the model cost-effective?

Material
The participating health care organizations are in two Finnish municipalities. Totally we are implementing the model in 8-10 teams.

Method
A mixed methods design will be used including both qualitative and quantitative data collection. All staff members get a questionnaire to answer in the beginning and at the end of the project. Both focus group and individual interviews will be used to evaluate the team members experience of work satisfaction, management, teamwork and trust. Additionally the superiors and responsible superiors of the organizations and clients will be interviewed in the beginning of the project, in middle of the project and at the end of the project. Health economical calculations shall be done within both organizations.

Results
The research project is going to begin, no results can be presented. However, discussion concerning methodology and other project issues is welcome.
This research relates to all concerns at NOVO triangle. Concerning patients and quality of care the Buurtzorg model has shown higher client satisfaction than does traditional care of elderly. The model has also shown to be economic and in such way, it responds to society and efficiency. Concerning employees and work environment the model shows to be sustainable and according to evaluations done, the model also shows increased work satisfaction among team members.

Workshop:

"The Nordic model": historical origins and its significance for the work place dialogue towards increased organizational sustainability

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The vision of the NOVO network is "a Nordic Model for development of more sustainable production systems in healthcare". It is based on the assumption that the Nordic countries, through high levels of trust and justice (social capital), have unique opportunities to carry out dialogue-based change processes, cf. "the Nordic Model". This seems important due to the frequent negative impact of rationalization on ergonomics and vice versa (see previous abstract by Winkel et al). The Nordic model has been the subject of extensive discussions and studies (e.g. Schiller et al., 1993).

The Nordic exceptionalism might first be noticeable in the Middle Ages in the weak feudalism compared to the Continent. The peasants of the North were personally free and owned their land. They paid taxes and were the direct subjects of the Crown. Correspondingly, the nobility was weak.

At the time of the industrial breakthrough in the 19th century, industrial workers were recruited from the landless, often sons and daughters of self-owning farmers. Before the advent of the labour movement, dialogue instead of violence was the trusted way for the popular movements to advance their cause. The international revolutionary orientation of the trade unions was already during the 1890s subordinated to negotiations with national employers.

The collective agreement is the counterpart to the share contract (in Danish: "Andelskontrakt"), which created and structured social capital in the agricultural development in Denmark. The collective agreement also begun its successful spread in Denmark and became dominant in the whole of the North.

The class conflicts took place in countries without major ethnic, cultural and religious splits. In a European comparison class differences were relative moderate. The state had a limited record of active repression and corruption.

To-day we still have the best organized trade unions in the world, close cooperation with important social democratic parties, strong employer organizations, early recognition of trade unions and established policy of collective bargaining with close to total coverage of the labour market and a principle of no-state intervention in industrial conflicts. Thus, the industrial relations in the Nordic countries still seem to be exceptional.

Key research issues are now to further investigate the Nordic Model in terms of:

- ✓ critical prerequisites for a positive environment for dialogues based on workplace agreements,
- ✓ how such insights can be measured and further developed,
- ✓ how they can be made available to a wider audience in an applicable way

Service integration and new competences in health and social care

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Introduction
In Finland large reform is planned in health and social care services. All health and social services would be under responsibility of counties (now municipalities), which has been done in two areas already. The aim of the reform has been to comprise economic development by creating new, larger and stronger organizations as well as to build integrated services and service chains. One aim is to increase customers' choice of provider and to increase the number of service providers and to have competition in the market.

In this paper we analyze the reforms which already have been done in terms of care integration and competences needed.

Methods
The study is a part of a large Cope-project which aims to evaluate the competences needed in future health and social care. This paper is based on interviews of 20 top and middle managers. The data was collected from three large health and social care districts. One district has been in action for several years, one has just started and one is been planned.

Results
The first results from interviews of managers showed that care integration is done using three strategies: collecting services to same organization, improving co-operation between organizational units and professionals and using care integrators or case managers. These strategies vary in different sectors and districts. Same districts may use all these strategies. The reform planned by government worries the managers in terms of care integration, which is relating to multiple service providers and market orientation. Different types of care integration have impact on competences needed. For example understanding the services needs of customers in more holistic way (not only in point of view of own work unit) and understanding the services system better is needed. There is a need to create multiprofessional work, and building trust and understanding of other professionals work is needed.

Conclusion
The first results of the study showed that service integration is a strong emphasis in all participant organization, but the means differ. There are several generic competences which should be at better level in future.

New technology in developing interdisciplinary teams

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Introduction
In the last decades we see an increasing specialization between hospital professions, and thereby demands for efficient communication between professionals that are only possible when they are able to perform in teams. The high impact and tight time schedules in medical groups, emphasize the groups' ability to make the best decisions under rapidly changing conditions and/or high levels of stress. To improve interdisciplinary team's performance it is necessary to increase team-members awareness of their interaction. Direct observation has been the only method to get information of a teams dynamics over short periods of interaction. Since direct observation requires trained observers and extensive labor and time, it is frequently replaced by quick and easy measures (e.g. questionnaires), with often disastrous results for teams-performance. Advanced Technology may speed up the process of direct observation of team interactions and make it useful for real-time feedback.

Aim
The aim of this paper is to show how the use of electronic sensors to measure interaction in teams can be used for feedback purposes in team-building.

Materials and methods
Our research group Operational Leadership (NTNU), has tested the use of electronic sensors, to see how they can capture elements of team-dynamics that relates to existing academic work on groups. We have gathered sensor data from a variety of different groups. In addition data is gathered using the SPGR (Systematizing the Person-Group Relation) method.

Results
We found that electronic sensors definitively have a large potential for both researchers and practitioners on teams. We also find that the extensive data collected are particularly valuable for mapping the dynamics of a team and can be used in combination with, or even replacing, direct observation as method. Focusing the dynamics of influence within high performing teams, we found a consistency between the sensor data and data gathered from a validated tool on group dynamics, (SPGR).

Conclusion
In this paper we discuss the use of electronic sensors as method for observation of group interaction, and how the technology can be used to improve interdisciplinary teamwork in hospitals.

Keywords: *Group-dynamics, interdisciplinary teams, Electronic sensors, Group-observation, SPGR*

Workshop: The art of building high-performance teams – an introduction to the use of SPGR for researchers and practitioners.

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The Systematizing Person-Group Relation (SPGR) method is an operationalization of the Spintheory for groups and includes a set of tools for organizational, team, and leadership development. Today teams are increasingly used to solve organizational problems and tasks. No teams are created equal, and nor should they. To be effective a team have to change its dynamics to meet the requirements from both the context and the task. Knowledge and skills on how to develop a team's situational awareness are mandatory for optimal performance. For any change processes the group is key for success. This is true both for organizational transformations and personal development.

In this workshop we will introduce the SPGR systematizing person group relation method and its use in organizational transformations and development. The participants will gain hands on experience in using SPGR tools to map role structure, mental models and other aspects of team dynamics. Every delegate will get their individual report summarizing team's dynamic, their own role in the group and perceived interaction (mental model) as an example on feedback material to be used in individual and group development.

Workshop overview:
- Introduction
- Spintheory and SPGR
- Implicit values – a short exercise
- Implicit values and the basic group functions
- How to rate a team with SPGR
- Group learning and levels of purpose (contextual demands)
- From theory to feedback: the SPGR space
- The future of team-building and team research

Keywords: *Group-dynamics, Team-building, Electronic sensors, SPGR*

Social capital – a resource associated to intention to leave among health care professionals

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Introduction
Hospitals in Sweden are redesigning their care processes to increase efficiency and in the same time maintain the quality. However, related to these changes, there is a risk of increased staff intention to leave and turnover due to increased workload and work pace. The literature on job demands and resources suggests that specific job resources can buffer negative effects; i.e., intention to leave because of job demands. Social capital has in earlier research shown to be important for employees´ job satisfaction and to health care staffs´ engagement in clinical improvements of patient safety and quality of care. Social capital is suggested to have the potential to be a resource associated with health care professionals' intention to leave.

Aim
To investigate the associations between social capital and intention to leave and to test if social capital moderates the relationship between job demands and intention to leave. Three hypothesis were formulated and tested:
1: Social capital is negatively associated with intention to leave.
2: Social capital moderates the relationship between job demands and intention to leave.
3: Levels of social capital are associated with levels of intention to leave, such as high levels of social capital being associated with low levels of intention to leave and low levels of social capital being associated with high levels of intention to leave.

Materials and method
Five hospitals working with improvements of care processes were studied using a questionnaire administered to the clinicians (n = 849). Bivariate associations was investigated. A Student's t-test was used to compare if levels of social capital in relation to levels of intention to leave differed. Linear regression models were used to investigate if social capital moderated the relationships between job demands and intention to leave.

Results
The hypothesis 1 and 3 was confirmed while hypothesis 2 was rejected.

Conclusion
Social capital was associated with healthcare professionals' intention to leave. Levels of social capital was associated with levels of intention to leave, such that high levels of social capital are associated with low levels of intention to leave. Social capital did not moderate the relationship between job demands and intention to leave.

Visual management; Condition or consequence to social capital and clinical engagement among nurses?

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Introduction
Collaboration and communication in health care can be supported by using visual management (VM) in patient and/or improvement work. Research shows a positive association between social capital (social reciprocity, trust and collaboration) and clinical engagement among health care staff. VM research shows to give social, cognitive and emotional benefits which improve engagement and commitment to work. The aim of this paper is to explore whether VM act as condition for or consequence of social capital and clinical engagement among nurses over time.

Methods
Five hospitals (20 units) were included in a three year study. Questionnaire A (QA) was distributed to nurses (T0 N=948, T1 N=900, T2 N=621). The observed presence of VM at the hospitals increased between T0 and T1. Hence, questionnaire B (QB) was distributed (T1) to first line managers (n=20) to identify units with a higher degree of daily VM use. QA validated QB concerning nurses daily VM use (T1), and measure the indices; social capital and clinical engagement in patient safety work and care quality (T0, T1 and T2). To compare differences between units with higher daily VM use, to units with lower daily VM use, means with Wilcoxon signed rank was used.

Results
Combined QA and QB analysis (T1) identified four higher use units (n=148) to be compared to lower use units (n=719). Nurses at higher use units (HVM) rated higher social capital than nurses at lower use units (LVM) all three years. No difference in social capital where seen within HVM T0-T1 or T1-T2. A small increase in social capital where seen within LVM T0-T1 and an equally small decrease T1-T2. HVM rated higher clinical engagement in care quality all three years, but no significant changes over time where seen within HVM or LVM.

Conclusions
Following nurses undergoing care process redesign, social capital seemed not to be a consequence of VM use but a pre-condition for higher VM use. Similar to previous studies, clinical engagement was an outcome of social capital. However the result shows signs that VM use may act as a buffer on social capital for nurses undergoing care process redesign.

Implementing Aseptic Techniques in the Operating Room: Facilitating mechanisms for Contextual Negotiation and Collective Action

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Background
Hand hygiene and aseptic techniques are central to prevent hospital-acquired infections. Collective action and restructuring of social norms and relations in implementation processes in high-risk and complex environments, such as the operating room (OR), could facilitate the implementation processes of new patient safety practices during every day work. The aim of this study was to describe mechanisms supporting collective action and contextual restructuring bridging the gap between knowledge and practice in the operating room.

Methods
The study was set in a large operating room suite in a Swedish University Hospital. The theory driven implementation process was informed by literature on organizational change, learning and leadership, dialogue and the Normalization Process Theory. Interviews and participant observations were used for collecting qualitative data, which were analyzed using a thematic approach.

Results
Several context-specific mechanisms for collective action and contextual restructuring during different stages of the intervention were identified. The mechanisms were four different stage-specific mechanisms: 1) *partnership* as mechanism for collective commitment and resource mobilization, 2) *sense of urgency and awareness* as mechanism for progressively involving OR professionals. 3) *trust and psychological safety* as mechanism for negotiation for normative and relational restructuring to enable collective action, and 4) *co-creation of standard operational procedures* as mechanisms for integration and workability. The stages in the implementation process were iterative affecting each other over time.

Conclusion
The study contributes with descriptions of facilitating mechanisms in implementation processes. Findings demonstrates the importance of partnership and dialogue as mechanism for collective action and building a capacity for normative and relational restructuring. Moreover, supporting leaders and managers in implementation processes in healthcare seems to be crucial in order to integrate new practices.

Workshop:
The NOVO Network: the original scientific basis for its establishment and our R&D vision

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The NOVO network is a Nordic non-governmental professional association whose aims are to foster the scientific progress, knowledge and development of the working environment within Healthcare as an integrated part of production system development. The vision is a "Nordic Model for Sustainable Systems" in the healthcare sector. It was founded in 2006 in Copenhagen and was financially supported by the Nordic Council of Ministers from 2007 to 2015.

The motivation to establish the NOVO Network arose when reviewing the literature regarding opportunities to create sustainable production systems. This work was initiated year 2002 and resultet in a systematic review published 2011 (Westgaard and Winkel 2011). Already in 2006 it was concluded that ergonomic interventions have limited musculoskeletal and mental health effects in a long-range perspective while rationalization has predominant negative health effects – particularly within healthcare. This was the basis for creating the NOVO triangle emphasizing that intervention research for improved work environment in healthcare also needs to consider efficiency and quality aspects to increase organizational sustainability; i.e. the joint consideration of competitive performance and working conditions in a long term perspective.

Interventions aiming at increasing organizational sustainability thus demand new forms of collaboration and coordination between workers, management, designers, and ergonomists. Such collaborations will often be challenged due to the frequent negative impact of rationalization on ergonomics and vice versa. This call for dialogue processes between the stakeholders taking more holistic systems perspectives. Dialogue-based change processes may be more common in the Nordic countries compared to other parts of the world. It is argued that the Nordic countries have unique opportunities in this respect (see the following abstract by Schiller et al), with a potential successful outcome in terms of macroeconomic indicators (discussed by Olesen et al., 2008).

Thus, we suggest increased focus on our vision: "a Nordic Model for development of more sustainable production systems in healthcare". Future R&D performed within the framework of our NOVO network should substantiate this hypothesis. In practical terms, this necessitates expanded research protocols.

Sustainable organisation towards an attractive work environment in home help care

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Introduction
The work environment of nursing assistants in home help care is demanding, both from a physical, organisational and from a social perspective. Healthy workplaces are known by having positive, accessible and trustworthy managers. Leadership plays a central role. Organisational factors as clear goal, to know what is expected from you, possibilities to deeper your knowledge and possibilities to have influence and participate in developing the work are important for a good environment. The demographical changes urge for recruit and sustained qualified staff members. There is a need of improving the work environment to strengthen the employer's sustainability in a healthy organisation to secure future social care of older people and support their relatives. This paper is a presentation of an ongoing study, which aims to follow, support and evaluate the process of implementation of a work environment plan in the home health care organisation in the city of Gothenburg in Sweden. The municipality plans to develop an economic and social sustainable workforce planning and implement physical training at work time.

Aim
The aim of study is to on what contextual and what specific factors support the implementation and what hinder the development of a sustainable work environment. How does this affect the health of the employers and their relation with the first line manager?

Material and methods
The study has an activity theoretical design and qualitative and quantitative methods as health profiles/ questionnaires, Future workshops, interviews with nursing assistants and managers as well as observations of the nursing assistants daily work environment will be used. This far, the health profiles/questionnaires have been distributed to in total 282 nursing assistants in two interventions groups from two different geographical districts and in four control units. Further on five separate Future workshops has been completed with a total of 80 participants.

Results
Expected outcomes are to bridging the gap and the lack of knowledge between theoretical knowledge from earlier research and to gain knowledge of *how* home help care organisations can make this work in reality. Ongoing analysis and preliminary results from the baseline health profile/questionnaire and material from the Future workshops will be presented.

Shortcut to a better and safer care for patients with hard-to-heal ulcers

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Introduction
Patients with leg, foot and pressure ulcers are often older with different co-morbidities and treated for long periods due to the absence of structure, i.e. they lack early diagnosis, appropriate treatment and follow-up. For the health-care system ulcer treatment cause significant resource needs when considering the long healing time, where the main part of costs is related to nursing costs.

The Registry of Ulcer Treatment – RUT - is a Swedish national web-based quality registry used to capture areas of improvement in ulcer care and to structure wound management by registering patients with leg, foot and pressure ulcers. The registry, which covers more than 8200 patients, has shown a large potential for e-health solutions by making available a bed-side app.

Aim
To investigate how a bed-side app linked to a national quality registry can be used in everyday clinical wound management.

Material and methods
The app is an easily accessible tool, where the rapid initial registration can ensure that no ulcer patient is "forgotten". The app has been tested in some pilot municipalities and adjustments are carried out accordingly such as "image transfer" and "measurement of ulcer size". Image transfer can be used to follow the process of healing for the individual patient. Measurement of ulcer size is often asked for by staff as the ulcer size is one indicator of ulcer healing time.

Results
Clinical research data from RUT have shown significant reduction of ulcer healing time (by 64%), use of antibiotics (by 60%) and treatment costs (by 46%).
RUT´s steering group has become a *virtual center of excellence* for wound management with a multi-professional chat function, where staff gets access to a continuous E-learning.
The concept of clinical experience and research linked to a national quality registry has proven to be one successful approach to a more patient-centered and efficient health care system. Therefore, the registry received the award of The Golden Scalpel as the best innovator of Swedish health care in 2017.

Conclusions
Clinical experience and research linked to a national quality registry has proven to be successful for a more patient-centered and efficient health care system.

Workshop: To investigate how a bed-side app linked to a national quality registry can be used in everyday clinical wound management.

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Brief presentation of our topic
Being clinicians and researchers with special interest in wound management, we have focused on developing a national quality registry, RiksSår, for leg, foot and pressure ulcers to get a structure in everyday clinical work: early diagnosis, adequate treatment strategies, continuity of care and follow up at ulcer healing. The concept of clinical experience and research linked to a national quality registry has proven to be one successful approach to a more patient-centered and efficient health care system. Therefore, the registry received the award of The Golden Scalpel as the best innovator of Swedish health care in 2017.

RiksSår has integrated an existing mobile application, which can be used to facilitate registration and follow the patient's healing process. After testing the app, we find that further development of the app by adding features for image transfer and measurement of ulcer size would enhance its ability to become a smart and user-friendly tool for professionals who treat patients with hard-to-heal ulcers.

Involvement of the audience
We want your advice to improve the app and would like you to imagine yourself being a patient, a nurse and a manager, asking yourself the following questions:

How can an app be helpful to me? What are my needs for an app? Problems that an app could solve? Fears and wishes?

A discussion two and two during max 2 minutes and thereafter collecting the general views.

1- Patient: woman, age 81 with recurrent ulcers and a fear of changes
2- Patient: wheelchair bound man, age 31, with recurrent pressure ulcers and solid computer habits
3– Staff: assistant nurse, age 54 with no computer habits
4- Staff: assistant nurse, age 54 with solid computer habits
5- Manager of a health center: woman age 45, with special interest in keeping a low budget
6- Manager of a health center: man age 45, with special interest in improving the quality of wound management

Establishing a multidisciplinary day care surgery department: organizational change, institutional logic conflicts, compromises and consequences.

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Introduction
The study relates to *all three NOVO triangle concerns* by exploring challenges faced when creating and managing a multidisciplinary hospital department. The new organising model reported on was influenced by a business-like logic of efficiency and customer-orientation (*society/efficiency and patient/quality)*. The model diverged from the logic of organising around professional disciplines, which sparked reactions. The study trails the conflicts and negotiations that emerged within the organisation as different professional groups (*employees/work environment)* positioned themselves in the debate on and running of the new department.

Aim
The article contributes to understanding the challenges and possible solutions to implementing multidisciplinary organisational models in hospitals, and to the understanding of how conflicting institutional logics in the health care field are worked out on the ground.

Material and methods
Qualitative case study analysing in depth interviews and documents.

Results
Different groups argued based on different logics, and the traditionally most powerful professionals were not the only influential stakeholders in resisting change and shaping outcomes. The organising model was moulded into a hybrid combining professional and business-like logics in the process.

Conclusion
Implementing a model associated with business-logic in a hospital resulted in a collision of logics that sparked conflicts. The negotiated solutions and the consequences of these for the operation of the department, demonstrates how processes of institutional logic conflicts manifest on the organisational level. The study offers perspectives on why the re-organisation of professional groups is challenging, the potential compromises required, and insight into how the implementation process may create arrangements that remain as challenges in the future. Managers need to carefully analyse organising models in terms of which parts may be seen as problematic in their own organisation and invite all relevant stakeholders into participatory change processes. They must be willing to reach compromises, and adjust their proposed models. Change processes should involve foreseeing and planning for resolving challenges embedded in the adjusted organising model.

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